STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001136	A. BUILDING: _____ B. WING _____	C 03/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE PARK RESIDENTIAL CARE INC	2075 RIPLEY ST LAKE STATION, IN 46405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00144404. Complaint IN00144404-Unsubstantiated due to lack of evidence. Survey date: March 14, 2014 Facility number: 001136 Provider number: 001136 AIM number: N/A Survey team: Lara Richards, RN-TC Heather Tuttle, RN Cynthia Stramel, RN Census bed type: Residential: 127 Total: 127 Census payor type: Medicaid: 90 Other: 37 Total: 127 Sample: N/A Lake Park Residential Care was found to be in compliance with 410 IAC 16.2 in regard to the Investigation of Complaint IN00144404. Quality Review 03/14/14 by Lisa McColly	R 000		